

Papers on:

Policy Issues in Wisconsin

People who are homeless in Wisconsin

Relevant Policy Issues in Developing a Wisconsin State Plan
for People who are Homeless and Mentally Ill

A Tentative Accord on Housing the Homeless Mentally Ill

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Homelessness in Perspective

During the European settlement of the U.S. temporary housing was common. However quite early in the settlement phase there was a recognition of the public responsibility for the housing or sustenance of the poor and the pauper. Early relief giving was based on traditional attitudes and policies derived from the English Poor Law system of relief. In this system a person was attached to a specific place [a Parish] and it was the responsibility of the parish to regulate the welfare of its indigent population. The eastern colonies and later the frontier states inherited the "local" pattern of relief and punishment for the indigent and vagrant classes. In Wisconsin the civil units of towns and counties substituted for the English parishes.

In Wisconsin, 1838 saw the first act for the provision of relief and support for the poor. This Territorial Act placed responsibility for relief with the county board commissioners. As towns and counties were organized, provision for the destitute was seen as an essential element in local government. Almost without exception responsibility for relief was adopted within the first year; indeed many towns and

counties had methods of relief prior to formal formation. In 1849 the new State of Wisconsin legislated for both county and town systems of relief. The mixed pattern of responsibility for relief has continued almost to the present time.

Historically, treatment of the indigent and dependent population in Wisconsin varied radically depending on public and administrative attitudes toward the cause(s) of an individual's dependence. As in many other states, the 'deserving' were given much better treatment than those perceived to have some degree of responsibility for their poverty or disability. By the 1860's there were several institutions established for segments of the dependent population (blind, deaf, insane, and delinquent boys). The indigent who did not fall into these categories (and some who did) were usually confined to local poorhouses. While the state institutions were generally overcrowded and under-staffed, appalling conditions existed in the local poorhouses. The county and town poorhouses were designed to discourage use. Located in isolated areas, their inhabitants faced poor food and lack of beds, sanitation, and even fresh water. In the words of the Board of Charities and Reform 1871 investigation conditions were 'filthy', 'disgusting', 'offensive', with 'beds full of vermin', 'walls clotted with blood', 'urine running over the floor', and 'a disgrace to the state'.

The reform movement of the 1870's sought to improve the lot of those people already identified as 'deserving' as well as to extend the

definition of 'deserving'. In 1878 and 1881, the "Wisconsin System" of county asylum care for the chronically mentally ill was introduced in an effort to relieve the overcrowding and mixing of people with mental illness, mental retardation, and the "chronic insane" at the state mental hospital, poorhouses, county jails and insane asylums. As a consequence 27 county asylums were constructed between 1880 and 1900.

Many mentally retarded people who were technically excluded from these facilities were classified as "insane" and committed to county asylums. However, as the cost increased the state (in 1894) responded by forcing counties to strictly enforce eligibility criteria, thus reducing state reimbursement. The net result was a surge of mentally retarded people who were admitted to poorhouses in the next three years. This example of progressive reform improving conditions for some, excluding some, and the subsequent adjustment by the service system has been repeated several times in the course of Wisconsin welfare history. In general, the aim of separating the deserving from the undeserving indigent has been conditioned by the cost of serving all those defined as deserving. The 'most deserving' were aided first and at the highest levels. Often 'most deserving' in the case of the indigent meant the quiet, clean, well behaved person who complied with treatment and was not disruptive.

As the state began to serve segments of the population previously unserved or underserved, advocacy for expansion of those who would be

eligible for services increased. Such advocacy embraced, for example, mentally retarded children, disabled aged, and people, particularly children, with multiple disabilities. While the State of Wisconsin moved into a more active position with regard to the dependent population the growing urban areas presented a new phenomena for Wisconsin: the emergence of urban concentrations of poverty. In the thirty years prior to the turn of the century, slums emerged in the larger towns and cities. By the 1890 Census it is possible to identify definite areas of the larger cities where concentrations of poverty and low quality housing coincide.

The Census primarily counted the domiciled population, but as the numbers of the poor increased, concentrations of homeless and near homeless individuals and families could be observed living in the open, in shanty towns, or in boarding houses. Relief agencies focused on these areas; their activities drew still more people who were homeless and discouraged competing activities. The outcomes of public policies which forced people who were homeless to leave specific locations included the establishment of relief agencies in areas of concentration of the poor and the focus on relief of current crisis needs (food, shelter), rather than long term solutions.

The Depression of the 1930s led to widespread poverty in Wisconsin, exposing the inherent structural problems of administering the Wisconsin system of relief. For the first time in Wisconsin, local units were directly aided by the state for the provision of public

assistance. Moreover, for the first time the state treated local units differently according to the amount of need and the local unit's ability to meet that need. Federal funds for relief ended in 1936 and a reorganization of relief activities quickly followed. In general, counties became the focus of relief (42 counties), while local units remained in control in 14 counties, and in 15 counties local units formed groups to administer relief. The mixed pattern of relief administration thus continued after the Great Depression and into the 1970s.

One legacy of the Great Depression for the welfare system was the Citizen's Committee on Public Welfare (1937). The Committee made many recommendations including the transfer of relief activities to the counties, the state funding of support for transients, and a work-based relief program for the unemployed. The recommendations of the Committee had little effect and the fragmented administrative structure continued. Again, there is a striking parallel with the reform era of the 1870s when a Statewide reform committee made wideranging reform recommendations with little consequent reform.

The upturn in the economy during the Second World War reduced the destitution due to unemployment. The burden of relief was not entirely eliminated due to the number of people who were unable to work or were transient. There was little direct federal involvement in programs for the indigent in this period. The new Social Security system did not really grow substantially until after the end of the

war so that most relief depended on local or state resources.

In the post war period pressures on the relief structure stemmed primarily from the growth in destitution due to unemployment. In the 1950's transient people were still vulnerable to arrest and vagrancy charges. The person with mental illness was also vulnerable to institutionalization which was seen as the most appropriate care for many types of mental illness. This is also the period of the introduction of major efforts directed toward the treatment of alcohol abuse as a disease rather than criminal offense. The change in attitude toward the abusive use of alcohol led to confinement in treatment facilities rather than jails. Thus several segments of the traditional homeless population were removed from the destitute group by being confined or moved on to another jurisdiction.

By the mid 1960's the elimination of substandard housing and skid row areas was seen as a viable public policy. The relative prosperity of the period had contributed to a decline in the number of people who were homeless and consequently the notion of urban renewal was seen as a practical method of dealing with the homelessness problem. It was thought that by removing the cubical and SRO hotels, people who were homeless would move to better accommodations (which in theory had been left vacant by households leaving the city). However, at the same time as skid row was being "renewed" other housing was being demolished or upgraded. Federal and city building standards required removal or renovation of substandard housing. In the 1960's these

standards became progressively more stringent. The net result was a drastic reduction in availability of housing that was affordable for those in extreme poverty.

The upgrading of housing conditions and building codes were not limited to the large urban centers. Rural communities also enacted tighter building codes, often in response to state and federal aid programs. Rural areas in Wisconsin were faced with increasing expectations from their residents and increasing requirements from state and federally-mandated programs. While many rural areas lacked the financial ability to pay for these programs building and zoning requirements were 'cost free'; sometimes such programs brought additional funds and were thus of great appeal to rural local governments.

In the period between 1970 and 1980 Wisconsin there was marked growth in the homeless population. By the mid 1970's the number of people with mental disabilities who were homeless began to be of serious concern to shelter providers and mental health providers. In retrospect the increase in the number of people with mental illness who became homeless seems to have occurred at the same time as the general problem of homelessness became more noticeable. Yet this was not the only segment of the homeless population that experienced significant increases in the 1970s.

The restructuring of the economy coupled with severe recessions has

produced high levels of unemployment. Most affected are those people least able to compete in the growth sectors of the economy. Thus as the demand for unskilled workers declines older unskilled workers become unemployed while younger unskilled workers can not enter the labor market.while younger unskilled workers can not enter the labor market. The net result in the late 1970s was a growing group of people who while willing and able to work could not find jobs in the labor market. With few resources these people became vulnerable to homelessness when their various entitlements (unemployment compensation, job training etc.) expire.

The late 1970's and early 1980's have seen the addition of more and more families to the homeless population. The rapid rise in rental rates, coupled with the virtual elimination of public housing construction has squeezed many families out of the housing market. In addition there is an increasing number of single parent households for whom securing adequate housing presents considerable difficulties. For many single parent households, their income generating potential is too low to secure adequate housing. Thus even when working full time they are unable to support their family in an economy which is increasingly based on two income households. The families that become homeless place additional burdens on emergency housing services. Like the mentally ill person, families have special needs that traditional shelter providers have not been accustomed to meeting in the past.

Recent Increases in Homelessness in Wisconsin

The early 1980's saw the size of the homeless population of the U.S. increase dramatically. In 1983 it was variously estimated to be under 1 million (HUD) to as high as 2 million. In the last three years the national trend has been upwards, with the generally accepted figure standing at 2 to 2.5 million people per year. At the local level, the trend has also been upwards, but the rate of increase seems to depend on local conditions such as unemployment rates, and policies such as welfare and housing policies. While the absolute size of the population is a subject of considerable debate, there is a consensus that people who are homeless have significant problems. Approximately 40% of people who are homeless are heavy users or abusers of alcohol, 30% suffer from chronic mental illness, and virtually 100% are destitute.

In Wisconsin, the number of people who are homeless has been estimated at 22,000 (using the most conservative (HUD) approach) to 43,000 (using less conservative estimation methodologies). The precise number is not particularly relevant in the sense that the most conservative figure is cause of serious concern. In constructing programmatic initiatives, estimates of the size of the homeless population is important for cost estimates: the need for some response, however, is demonstrated by even the most conservative estimate.

A survey of all known emergency shelter providers conducted as part of this research project yielded much information on the number and characteristics of people who are homeless in Wisconsin. The data, which was for 1985, indicates that on the average night in Wisconsin just over 500 people are sheltered through the agencies covered in the survey. On a yearly basis this represented a minimum of 17,763 individuals. Other research has indicated that for every person sheltered 1.3 to 1.5 individuals are not sheltered. Applying these ratios to the unduplicated count yields an estimate of the number of homeless in 1985 in the counties and communities covered in the survey of between 23,091 and 26,644. The figure for the whole state will of course be higher, but it is difficult to estimate how much higher since the omitted counties and communities are primarily rural and semi-rural and probably lack formal emergency shelter systems.

The homeless population of Wisconsin is very similar to the national homeless population and that of other midwestern states. Men and women are now more evenly represented than in the past, but this is largely due to the presence of large numbers of family groups (whose members were 63% female) since the homeless single population has remained predominantly male (71%) although this male predominance is declining rapidly; it was estimated in 1983 that males comprised 85% of the single homeless population. The population is much younger than even a decade ago, with families being a significant portion of those in shelters, but there are also larger numbers of young unemployed

Causes and Effects of Homelessness

a. Housing Markets

The growth of the number of people who were homeless that occurred in the 1970's surprised those who had predicted the demise of skid row and substandard housing in the 1960's. However, it is not so surprising if we consider the effects of a mix of Federal and State policies during the period. Urban renewal policies removed much of the lower end of the housing market in central cities, while stricter building standards raised the cost of housing in both rural and urban areas. For example, nearly half of the nation's SRO units were demolished or otherwise removed from the housing stock in the 1970s. The very poor resident could not afford or function in the remaining housing without a significant increase in social and economic supports. While economic and social support programs did increase, these program changes were not sufficient to ensure housing for many skid row residents. In the 1970s the total number of low income renter households fell from 13 to 9.2 million, but the number of available units also fell from 17.9 to 6.4 million (Low Income Housing Information Service).

In the 1980s low income housing has continued to decline. Federal subsidies for low income housing have fallen from \$27 billion in fiscal 1980 to \$10 billion in fiscal 1984. This is in a period when

private housing construction was in a serious slump and few older units became available through filtering. In most major cities waiting list for public housing are being closed as the waiting periods grow longer. Smaller cities and towns have seen the elimination or reduction of housing programs. The increasing complexity of federal regulations has exacerbated problems caused by the shortage of funds. Local housing authorities are faced with the situation where there are homeless people and vacant public housing. A homeless family, for example, might be denied public housing because of the lack of a security deposit or furniture. In effect, they are too poor to secure what many believe to be housing at the bottom of the housing market.

While many housing units that might have sheltered people who are homeless have been removed from the housing market, others have become unavailable due to increasing cost or other barriers to access. It is widely believed that renovation and gentrification of downtown housing has made a significant number of people homeless by displacing inner city residents. Apart from the removal of large numbers of SRO units, the data is to date not conclusive. However, the net effect of downtown revival, by raising the general level of downtown rents, has been to limit the number of housing units available to the very poor.

The problem of housing the homeless population extends beyond the number of available housing units to include the type of units available. Certainly the loss of SRO housing has been a major source

males and females. Most people have no income: 45% of people in families and 58% of single individuals. Single individuals who do have some income are overwhelmingly on general assistance; families who have some income are predominantly receiving AFDC, with some receiving general assistance.

Eviction by landlords, roommates and family disruption were the leading immediate causes of homelessness. However, the underlying cause was usually destitution. That is, the eviction was usually because of non-payment of rent. Since people become homeless because of destitution, and being unable to afford to travel they usually seek help in their own community. Three-quarters of the clients of the surveyed agencies came from the same county, and only 13% were identified as being from out-of-state. The proportion from out-of-state appears to vary with location and type of agency. Voucher programs such as those operated by the Salvation Army from United Way funds have a higher proportion of out-of-state clients than direct service providers, for example.

People who are homeless are often categorized as 'problem people' rather than people with problems. The information gathered in the course of this study indicates that the most pervasive problem is poverty. Families, in particular, are faced with poverty as their main presenting problem' (over 50%). Single people who are homeless also have poverty as their main problem (over 40%), but many also have the additional complexity of mental disability (20%) and/or substance

abuse (26% - primarily alcohol).

It is the overlapping problems of people who are homeless that presents difficulties for emergency shelter service providers. For example, a person who is an abuser of alcohol, suffers from chronic mental illness, and has low job skills does not fit neatly into existing programs. Even the simple provision of shelter becomes a problem because rules which were normative in former years now present difficulties in the light of the changed needs of the homeless population.

The rapid growth in the numbers of people who are homeless further exacerbates the problem. Because there has been a lag in the allocation of funds to meet current needs, shelter and other service providers have been swamped with demands. Many agencies are devoting the majority of their budgets to emergency care, making little provision for long term projects which could bring the homeless in off the streets permanently.

of problems in large cities as well as in more rural areas. However, the population that is now homeless is somewhat different than that of the past. For example, more young people, more mentally disabled people and more large families are becoming homeless, indicating needs that the housing market is not meeting. Young people with very low or no income, but who do not live at home need inexpensive housing as they establish themselves in the labor and housing markets. People with mental disabilities may need structured and semi-structured accommodations that the housing market has not traditionally supplied and communities resist. Large families face increasing difficulties in finding affordable housing that will allow the family to remain together. All these groups may additionally face discrimination in the housing market. The discrimination may be based on their characteristics (age, mental disability or household size) or on the label 'homeless'.

b. Poverty, Unemployment and Destitution

Over the last decade there have been increases in unemployment in both the state and the nation. This unemployment would normally be transient in nature, but has become chronic in some localities and industries. Wisconsin saw a major loss of manufacturing jobs in the 1970's as employment growth focused on Sun Belt states. This ongoing restructuring of the manufacturing sector has been matched by continued restructuring of the rural sector. The rural crisis of low farm prices, excess production, and soaring costs has reduced farm employment to an all time low. Thus, Wisconsin is experiencing instability in two of its major employment sectors.

Unemployment does not necessarily imply destitution. Indeed, for most workers loss of a job may not imply any loss of income since a new job is often secured before the termination date. There are some workers, however, for whom loss of a job can have severe consequences. These are people who hold particular skilled jobs (such as automobile manufacture) for whom retraining will be necessary, older workers and people with few work skills.

In addition there are groups of individuals who face particular difficulties in the labor market because they have never been employed or have been out of the labor market for long periods; never employed young people, displaced homemakers, and released inmates of criminal justice or other stigmatizing institutions.

In sum, these groups constitute a whole range of people who are "second choice" for employers. These individuals face competition from better qualified or otherwise "first choice" individuals. In periods of prolonged unemployment this competition is particularly strong as the more desirable workers can take jobs below their skill level and hence crowd other workers out of their normal segment of the labor market. For instance, a person who is a day laborer may normally be able to pick up a few days work at a car wash, but with increased pressure for employment a college student may seek the car wash job, crowding out the person who would usually fill such casual positions. The net effect is to push the marginal worker out of the bottom of the labor market. Eventually these workers, become discouraged and are not counted in unemployment statistics. Because of the marginal job skills of these workers a period of unemployment can have devastating consequences since they are unlikely to have amassed significant assets to tide them over the period of unemployment.

In general, people who appear to have become homeless due to loss of employment tend to be marginal workers in terms of skills or work experience. These people have often been 'on the margin' for some time, so that re-employment involves over-coming a poor work history.

c. General Relief housing payments

Housing costs place severe pressures on the financial resources of many individuals. A person who is destitute often lacks the ability to purchase any housing and may turn to public resources such as general relief. General relief has been used throughout Wisconsin to varying degrees over time. In the last century these payments were called outdoor relief to distinguish them from indoor or almshouse or poorhouse payments. The idea of paying cash to the poor for food, clothing and shelter was generally thought to foster independence and to keep costs low.

Current administration of general (outdoor) relief usually includes payments for food, personal expenses, shelter, and often medical care. In theory the individual secures housing in the private market and the cost is subsidized or paid in full by the general relief program. Obviously, if the person already has housing there is no need for the payment. As the cost of housing climbs more and more general relief recipients are unable to find affordable housing. This is exacerbated by the need for security deposits. Without housing, the person can not obtain the general relief housing payment. Thus, a person who might be able to rent a room on a casual basis for part of the month is forced on to the street.

It is perhaps ironic that public relief which is the last strand of the social safety net can act to deprive a person of their ability to

secure housing. To obtain general relief a person must lack resources. A person who is accumulating money toward a security deposit, however, may lose their general relief eligibility if they have any other assets.

d. Mental Illness, Deinstitutionalization, and Community Support
Programs

Housing and income policies were not the only policies which contributed to the rise in the number of people who were homeless in the 1970's. The deinstitutionalization of people with mental illness which began in the mid-1960's reached its peak in the early 1970's. Some of the deinstitutionalized population became homeless and swelled the number of people on the streets. These individuals also fundamentally altered the characteristics of the homeless population. For most of U.S. history the homeless population contained relatively few people with mental illness, particularly when compared to the two major components: the economically disabled (the working poor and destitute) and the physically disabled (including the alcoholic). These two major components fluctuated in size with public attitudes and the state of the economy. Deinstitutionalization of people with mental illness thus added another major component to the homeless population, a component that service agencies were often completely inexperienced in dealing with in a community setting. Initially the chronically mentally ill person who became homeless had been deinstitutionalized and tended to be middle aged. More recently younger people who have been denied admission to mental hospitals have been added to the population. Thus, the mentally ill component of the homeless population has within it considerable variations in past experience and contact with the mental health system.

People with mental illness have long been a component of the homeless population. To the extent that they were seen as unintentionally ill, disabled and mentally ill persons have been viewed as deserving better treatment than the derelicts and bums of skid row. With the advent of deinstitutionalization in the mid-1960's people with mental illness were progressively released into the community where support services were to be provided. The hospital was to provide crisis care and ongoing care for those who were unable to live in the community. Involuntary admission was, in general, governed by the "immediate danger" standard which required that a person be an immediate danger to themselves or others. A large pool of vulnerable persons was thus created within communities unused to dealing with such persons. This pool grew further when persons who would formally have been admitted to hospitals were instead placed in community-based care systems. In terms of treatment, community based care has been recognized as an advance over previous methods. In terms of control, deinstitutionalized persons are certainly spatially and temporally freer in their behavior. In terms of quality of life, most analysts agree that there has been an improvement for the vast majority of mentally ill persons.

If community support fails, however, the usual assumption might be that the individual should be confined in an institution. However it seems that there are an increasing number of persons for whom life on the streets is the alternative. Concern over this outcome leads to a consideration of ways in which community support can fail. The

failure with respect to people with mental illness who are homeless is complex in nature and has a variety of consequences. There are several sources of failure:

1. Deinstitutionalization: Were patients inappropriately discharged? Have we simply transferred the backwards to the streets?
2. Non-admission: Are new clients not being admitted to hospital care when their condition warrants admission?
3. Placement: Are clients being placed in vulnerable situations where they are likely to become homeless?
4. Support: Is there adequate community based support?
5. Re-admission: Are people kept out of hospitals in times of crisis? Has the revolving door closed with clients left out in the cold?
6. New-placement: Are there adequate mechanisms for resettling people who become homeless? Are the shelters sufficient to reintroduce a person back into a settled life style? Do the shelters act as portals to the society or as gatekeepers? (It is important to note that the shelter providers often see themselves as portals while the clients often see them as gatekeepers).
7. Service delivery: How responsive are existing modes of service delivery to the complex problems of people who are homeless? Are the institutional structures part of the problem rather than the solution? Do service agencies view persons who are homeless as individuals with problems or as problem individuals?
8. Housing policy: How has urban housing policy responded to the demands of mentally ill persons for inexpensive housing? While pursuing urban redevelopment have urban policy makers exacerbated the difficulties faced by persons who are homeless?

Each of the areas outlined tend to be intimately related because of the integrated nature of the health care system. However, it is important to note that it is the conjunction of conflicting policies rather than intentional individual actions that have allowed people to

fall through the cracks. For instance, in the late 1960's did policy makers intentionally decide to urban renew downtown hotels or upgrade building codes so that newly deinstitutionalized persons would have nowhere to go? Obviously not, yet this removal of housing had a great impact on the available housing, and did contribute to the increasing number of persons with mental illness who are homeless.

e. Alcoholism and other drug abuse

Use and abuse of alcohol has long been associated with homelessness. In Wisconsin, shelter providers estimated that 12% of people in families and 26% of single people were substance abusers. The majority of the people seen by these providers were abusing alcohol. The role of alcohol abuse among the un-sheltered homeless population is thought to be much higher than the sheltered group (because intoxication is a leading cause of denial of shelter). Drug use and abuse is not as prevalent as alcohol abuse except for the younger age group.

A need for additional treatment beds seems to be indicated by the number of people who are homeless and substance abusers. However, it is not known how many people would seek or accept the type of treatment now offered. A large proportion of homeless alcohol abusers have already passed through several treatment programs. Consequently it may be that innovative programs rather than just new treatment beds may be required.

f. Physical Illness, Disability and Aging

People who are poor usually lack health insurance so that a major illness can severely deplete any savings. It has been estimated that up to half a million Wisconsin residents lack adequate health insurance. For these families and individuals the lack of insurance leads to inadequate care and the cumulative effects of untreated diseases. The effect is particularly severe when the person has health problems which impair employment possibilities. Lack of health care can then lead to lower earning capacity and lower standards of living.

Poor physical health usually does not in itself cause homelessness. It is yet another condition linked to poverty which can have compounding effects with the poverty of a family or individual. If the family or person becomes homeless their health condition is further threatened by the stresses and risks of life on the streets. Among the homeless population it is common to find high rates of malnutrition, TB, respiratory infections, hypothermia, hypertension, and digestive disorders. People who are homeless must also cope with lice infestations, leg ulcers, and trauma related to day to day living on the street.

Provision of health care for the homeless population under the Johnson grant has begun in Milwaukee. The care is a major initiative in reaching people who are homeless. Extension of the Johnson grant to

other communities is unlikely so those other Wisconsin communities will continue to have a homeless population with significant health needs.

Aging also plays a role in the process that leads to homelessness. Again it is not ageing itself but rather the correlates of low income and lack of employment that are more causally linked to homelessness. However, the aged person faces a particularly difficult time if they do become homeless. Because of their age and the felt or perceived vulnerability they are less able to compete for places in food lines or shelter queues. Some providers have recognised the added difficulties of the older person who is homeless by allowing an early seating at a food program for instance, or early admission to shelters.

g. Children: runaways and throwaways

Children who are homeless fall into three categories; accompanied by their parents, runaways, or throwaways (children forced from their homes). These categories are not absolutely distinct. For example, a child may runaway from home feeling pressure to leave and not be allowed to return.

Children who become homeless with their parents are separated from their usual way of life, schooling is disrupted, and they are often confused and frightened. The few studies that exist show that parents attempt to secure as high a quality of food and care for their children as possible, yet these children also show higher rates of malnutrition and other physical and mental health problems than domiciled poor children.

Children who become homeless with their parents are undoubtedly greatly distressed by the experience but do still enjoy the protection of their parent(s). Runaway or throwaway children are unprotected and are at higher risks of further abuse or exploitation. Shelter and voucher programs in Wisconsin do not accept unaccompanied minors, referring the children to runaway shelters or child protective service agencies. As with some adults, some children feel threatened by these agencies; that they will be forced to return home, that they will be institutionalized and so on. Unlike the situation of adults there are few options for the child who can not or who feels they can not return.

home. Most providers of low cost housing such as YMCAs or YWCAs will not take people under 18 years. Consequently 16 and 17 year olds who are essentially emancipated (through choice or through force) are left with few options. Their earning capacity is low because they usually lack adequate education so they are often unable to fully support themselves.

Summary

The increase in homelessness in Wisconsin has been extensively documented and is apparent in many communities. The causes of homelessness in Wisconsin are not substantially different than in most places in the U.S. While many communities have a long standing commitment to helping the poor and destitute the recent increase in homelessness has severely strained their ability to respond appropriately. Not only has the number increased but the addition of large numbers of families, people with mental illness, and young people has changed the service needs of the population.

The extent of the problem calls for concerted efforts on the part of all segments of the community. In many Wisconsin communities and other states, there is an emerging consensus that a public and private partnership will be needed to resolve the pressing issues of poverty and housing of the poor in Wisconsin.

Background Policy Issues in Developing A Wisconsin State Plan

for People who are Homeless and Mentally Ill

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People who are homeless appear to be 'prime candidates' for service delivery agencies. They clearly have many of the difficulties (economic, physical, mental, behavioral), which are the traditional 'turf' of such agencies. Yet they appear to be ill served at the present time. This paper suggests some initiatives that may impact the ability of Wisconsin's social service agencies to respond to the needs of the homeless population. But before going on to that discussion, let us examine the question itself. How bad is the service provision for the homeless population?

On an absolute scale one can say that the level of services is very low considering the magnitude and complexity of the problems confronting the person who is homeless. Some individuals have such significant levels of need that to fully meet their economic, health and other needs would be very expensive. Many agencies simply do not have the capacity to meet those needs (or must trade off the needs of one client for another's).

Yet if we look at the present situation from a long historical perspective one would be tempted to conclude that services have greatly improved and in fact stand at an all time high in the U.S.

Even if the national leadership makes statements about some people being homeless by choice, that is a far cry from Benjamin Franklin stating that the poor should be allowed to starve (with no governmental intervention) as an example for others. So what we have is two perspectives; historically services to the homeless have improved but comparatively they are still well below that available to others in the society.

Historical Sources of Public Policy on Homelessness.

Historically the poor have been a very mixed group in terms of their paths to poverty, their living conditions and their needs. The working poor, the suddenly poor, the vagrant, and the crippled beggar are all stereotypes to be found in the literature of most eras.

Services to the poor reflect a recognition of these sub-groups and judgements as to their eligibility and worthiness for aid.

Provision of shelter and support for the destitute has long been a matter of conflicting and at times incompatible aims. Feelings of charity toward the poor, the need for control, and the desire to reduce the number of dependent destitute people, have all competed in the formation of public policy. This conflict can be observed from the earliest period of colonization in the U.S. (and indeed in the source nations of the immigrants).

Just as there have long been destitute and homeless people there have been some segments that have presented difficulties for those

concerned with providing longer term housing. The notions of the "hard to shelter" and "hard to serve" are perhaps as old as homelessness itself. Services have in the past gone first, and in many cases have been limited to, the easy to serve.

If we examine the early European almshouses it is apparent that there were very definite criteria applied to those seeking help. In the U.S. colonial period there were two sources of destitute individuals; domestic events (such as death, insanity or insolvency), and immigration. The colonial administrations employed various measures to control the influx of individuals likely to become dependent on the public purse. These measures included posting a bond prior to landing, requiring a guarantor for a job or for support, and outright refusal to permit landing. In effect these administrations sought to prevent new arrivals becoming eligible for public aid. Some colonies even required a residency of a year after landing before the person was considered a member of the community (and thus eligible for aid).

Residents were in a different situation because they, by definition, meet a basic criteria of eligibility, that of residency. Access to aid in colonial America was relatively easy for the deserving who were already part of the community. Even if the aid was minimal and not that which was desired by the individual there was little debate that some aid was a right. Widows and orphans were almost universally aided. The aged, infirm, and insane were in general viewed by governmental bodies and charitable organizations as entitled to aid.

The aid was not generous and was highly dependent on the 'warden of the poor', much depended on the prior standing of the individual in the community.

However, just as there were criteria for entitlement there were conditions for the actual provision of aid. As might be expected overseers were appointed to supervise the care of children and others judged incompetent. Other individuals were not usually as closely supervised but there were explicit or implicit standards of behavior. Failure to meet those standards of behavior were frequently cited as reasons for discontinuing aid (the most cited was drunkenness, but foul language, disruptive behavior, sexual behavior, and even "gossip" and "backbiting" are mentioned).

As the numbers of potentially destitute persons increased, particularly in the nineteenth century, various measures were taken to limit the burden on states and localities. Measures included requiring complete exhaustion of personal resources and family support (extending to the degree of grandparents or grandchildren), increasing residency requirements, and compulsory work assignment. In addition behavior standards were more rigidly enforced to minimize both the cost of aid, in terms of money and effort, and to curtail the the numbers on the recipient rolls.

The most severe limitations were placed on the "able-bodied" and "non-resident" destitute. The former were not deserving while the latter

were not entitled however deserving. A consequence of these views was that governments discovered that by changing the definitions of "able-bodied" or "non-resident" they could substantially impact the public dependency rolls almost instantaneously. For example, farm laborers were often unable to earn enough during the summer to support themselves over the winter. By changing residency requirements from three to twelve months itinerant farm workers could be denied winter relief (and forced to move on) because they could not accumulate sufficient money to stay long enough to become eligible for relief.

The effort to "move along" the itinerant worker in the U.S. is linked to the view of the needy population as containing distinct classes; the poor (through no or little personal fault), paupers (ie the long term destitute), and vagrants. The poor and a segment of the pauper group were viewed as being worth/easy to help. Temporary support, job training or other transitional aid was usually sufficient to lift the individual out of destitution- if not out of poverty. The "hard to serve", and hence the most likely to become homeless, in this period were largely drawn from those persons who were long term paupers or vagrants. These individuals were variously characterized as lazy, incorrigible, violent, drunk, shiftless and petty criminals. A major element in nineteenth policy toward the poor was the isolation and exclusion of these individuals. Exclusion from services was seen as encouraging a return to 'normal' work habits, but exclusion from the locality was also a priority since that would remove the 'bad example' that these individuals presented.

Debates over who was entitled to aid and to what kind of aid revolve around the three latent issues in policies toward the destitute namely charity, control and limitation or containment of the numbers of destitute. For some localities in the nineteenth century vagrancy as a status offence became a major mechanism for removal of the poor to work sites (eg workhouses, poorhouses, and farm camps). Yet even here there were standards for behavior; and again drunkenness and disruptive behavior were the prime reasons for dismissal (which would often mean jail).

While in the 1800's there was concern about the ability to control the feared unruly elements of the poor this was also the period of large scale reform movements (Dix, Addams etc). This is not such a paradox because the reform movements were largely directed toward helping the "worthy" poor. The "worthy" poor were those who with some assistance would "rise" and these were to be aided. The "others" showed little promise and reformers of the period advocated that they should be excluded from services (because they were judged to be undeserving). Because many of the reform movement were religiously based there was a consistent concern for the "moral improvement" of those receiving aid. It is perhaps even fair to say that there was widespread feeling that the lazy (ie vagrants) should be actively punished and made to work. Yet at the same time there are also many examples of workhouses and almshouses taking in vagrants (at least into the outbuildings) on particularly cold nights.

Modern Social Service Structures

Over the last 150 years as governmental and charitable organizations developed more extensive social programs, two changes occurred that had the potential of decreasing the impact of destitution but also had the potential of increasing the problem of the hard core destitute. The first change has been the effects of reform movements in moving some groups of individuals from the undeserving able-bodied category to the deserving (sick) category by identification of an illness or other disability. Thus people with a mental illness, alcohol addiction or physical disability came to be regarded as deserving by definition. In effect efforts of containment of the deserving population had been relaxed which implied that there were more situations in which aid became a right rather than a matter of charity. With wider eligibility criteria and more recognition of "no-fault" destitution more people should become eligible for aid (there was of course the underlying funding limitation on the number of people actually aided).

The trend toward a wider definition of the deserving destitute was accompanied by and in part led to the development of more specialized forms of services and programs. These more specialized regimes have at least the potential effect of allowing great control over the destitute by channelling people into specific programs. Refusal of "treatment" can lead to a cut-off in aid. Moreover the development of a ever more rigid set of channels has also caused the development of

"cracks".

The mix of needs within the homeless population has emerged as one of the major difficulties in delivering services. The overlapping problems of people who are homeless presents difficulties for service providers. For example, a person who is an abuser of alcohol, suffers from chronic mental illness, and has low job skills does not fit neatly into existing programs. In the past the hard to serve person has tended to be the disruptive or "incorrigible vagrant" individual. The increased vulnerability to homelessness that these people experienced stemmed from them being defined as ineligible. Presently there is a growing number of "eligible but not placeable" individuals.

The rapid growth in the numbers of homeless persons further exacerbates the problem because there has been a lag in the allocation of funds to meet current needs, so that shelter and other service providers have been swamped with demands. Many agencies are devoting the majority of their budgets to emergency care, unable to make provision for longer term projects. Individuals who fit neatly into existing programs can be moved out of the shelters but those who do not fit exactly may be literally "left out in the cold". It is not surprising that social service agencies are choosing the "best fit" candidates in a period of limited funds. Indeed when funds become very limited it would not be unusual for not only the "no fit" but the "partial fit" to be excluded from programs.

In sum then, the level of services to the homeless population seems historically to have three determining components. The first is the eligibility criteria used to determine those who can claim aid as a right. The second is the general level of funding for the relief of the poor. The third is the way in which the priority list is drawn up when the available funds are not sufficient to meet all the needs of the eligible group.

In the past funds have never been sufficient to aid all those eligible so that the poor have been ranked by service providers. Clearly the best chance of 'success' are those poor who still have sufficient resources to maintain a dwelling so the homeless population as a class will tend to be ranked lower than the domiciled (indeed to obtain many services an address is necessary). People who are homeless thus experience a squeeze in resources when the needs of the domiciled poor increase.

Within the homeless population there is also a ranking. The best candidates for success being the first to be siphoned off into transitional housing programs etc. The residual group have been called the hard to shelter or the hard to serve and are a very mixed group of individuals. Historically, the major characteristics has been disruptive behavior (including drunkenness) and a perception that the person was an incorrigible vagrant (ie not willing to work). This historical view should be set against the very broad sweeping methods used in the past when dealing with the poor. All segments of the poor

would be thrown together, particularly in the almshouses, with only minimal regard for individual characteristics or needs. The hard to shelter or the hard to serve person was one who disturbed the smooth working of these institutions or who returned again and again.

In the current era, the hard to shelter/serve group still contains disruptive and repeating individuals but also those who do not fit into the new institutional and programmatic array that we have constructed. So many people are now homeless that the priority list has come to include, not only the disruptive and the chronic "repeater", but also those who encounter barriers to access to aid to which they are entitled. A major sub-group of these "no fit" or "partial fit" people are those individuals with mental illness (particularly if they also must cope with additional problems such as substance abuse).

It is as if the traditional almshouse of 100 years ago has been split up into specialist departments. In the modern period the specialist departments (sources of housing, physical health care, employment and training, food, and mental health services) are located all over the city. A person may be eligible to be in the almshouse but if the individual does not qualify for one of the departments, if the department is full, or if no department will take responsibility for the person they must wait in the lobby of the almshouse. The shelters of our urban areas and the vouchered rooms of the rural areas have become the lobbies of our now disaggregated almshouses. It is here

that the destitute person is given shelter for a short period until, at least theoretically, they gain access to the appropriate source of help.

Likely Duration of the "Homeless Problem"

In constructing any approach to the problem of homelessness it is necessary to recognize that while an individual may not be homeless for the rest of their life (though some will), the problem may continue for the foreseeable future. The magnitude of the current problem and the resources that would be required to adequately address the accumulated needs of the homeless population (for shelter and other services) would absorb any budgetary allocation for a number of years.

Beyond the magnitude of the current problem, there is the consideration of the structural sources of the current problem. These structural problems will require a detailed reevaluation and restructuring of public policy toward the homeless population. For example, the profound disengagement of the federal government from housing and mental health issues has ramifications that are only now beginning to emerge. Just as it took many decades to build up the federal role it will take some time to assess the consequences of its abandonment of its past role.

Public policy is usually thought of as including the goals and objectives which guide a government's actions. In the search for a policy on homelessness it will be critical to answer questions such as; Is there a public responsibility?, Who is eligible (what criteria are used and who decides)?, What aid is provided?, Who should

provide the aid?, and finally, Who pays?.

A Coordinated approach to housing the homeless mentally ill

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An Coordinated approach to housing the homeless mentally ill

Homelessness is not a mental health issue, it is a housing issue.

While people who are mentally ill make up a significant portion of the homeless population in Wisconsin, housing must be seen as a precondition to effective delivery of mental health services. Just as effective therapy is best delivered after the patient is stabilized, so a person who is homeless is placed at a severe disadvantage in obtaining effective mental health care. Without the stability of secure housing, facing the danger and stress of life on the street, it is not surprising that a person with mental illness would have difficulty in taking advantage of mental health services.

Housing alternatives for the homeless mentally ill population has often been viewed as a dichotomy; the institution or the community. A person who did not 'make it' in the community would be regarded as a candidate for re-institutionalization. As with most false dichotomies this one draws on past and present practices without really looking at underlying concerns: why is community care seen as superior to institutional care, and why do some people have difficulty living in the community?

Community care is advocated as an issue of personal liberty,

therapeutic practice, and fiscal efficiency. Institutional care on the other hand has been viewed as expensive, restricting basic freedoms, and of questionable therapeutic value except in crisis situations. The failure of community placement is complex but often has at its roots the poverty of the individual and an inability on the part of the housing provider, mental health care provider or the individual to deal with the particular living situation. In effect the 'community' as it is encountered by the individual may not be appropriate. This is a not uncommon experience in a society where people move, on average, every 3 years-- usually seeking an improved living environment. However in the case of a person with mental illness the normal residential dissatisfaction is often viewed as a failure in placement. Yet the need to change a person's placement in the community does not necessarily lead to homelessness. Other factors seem necessary to precipitate an episode of homelessness.

In examining the characteristics of the homeless mentally ill population it is apparent that people who are homeless and mentally ill are usually very poor and/or are coping with other problems in addition to their mental illness. In some ways they resemble the 'problem patients' of the old institution models. In the past the 'better' (more cooperative, better behaved) individual received higher levels of care in the institution, while less cooperative, less well behaved individuals were more likely to be heavily drugged and confined to the 'back wards'. Now that people with mental illness are in the community it is not surprising that the 'better' behaved person are

also better served. The challenge is perhaps not how to better serve the homeless mentally ill population but how to begin serving them.

One beginning is the provision of accessible emergency shelter.

Another is the provision of affordable, appropriate housing. Another is the provision of mental health services. Other beginnings are employment training and placement, physical health care, and ongoing social and economic support when necessary.

None of these activities are new, rather what is called for is the articulation of existing federal, state, and local policy initiatives in all of these spheres of public policy. In several of these areas there has been considerable change in levels of support and locus of responsibility in the last few years. As the federal government has moved out of both mental health and housing policy formation and support, responsibility (and the cost of services) has devolved to the states and localities. With this shifting of responsibility there is both the opportunity for the development of flexible locally based initiatives, and the problem of significant increases in demands on local and state government. Homelessness is but one problem which calls for the attention of the public and policy makers. Thus redirection, coordination, and improvement of existing programs seems to offer the best course of action.

A Three Phase Approach

There has been much discussion as to the 'best' method of dealing with the homelessness problem. State initiatives have varied from punitive efforts, aimed at getting rid of the homeless via zoning and other ordinances coupled with removal of services (including pressuring private charities such as the Salvation Army to close), to comprehensive efforts which aim at both immediate assistance and long run solutions. Recognizing the Wisconsin tradition of innovation in the area of social services and the strength of some segments of its mental health system leads to the expectation that the state of Wisconsin will likely develop a strategy on homelessness that builds on these strengths.

In considering how such a policy should be crafted political and fiscal constraints as well as the existing social service sector must be recognized. A policy strategy which disrupts existing programs as little as possible, yet, potentially, focuses considerable resources on the immediate and long run problems of the homeless population can be summarized as a three tiered or three phased approach. First, emergency shelter for those people now on the street. Second, facilities and/or services for stabilization and transition (and for prevention for those people vulnerable to homelessness). Third, permanent housing, employment and support where appropriate.

In the first tier physical safety is the immediate concern. In this

emergency phase shelter, food, clothing, rest, and financial assistance ready the person who is homeless to begin a sustained effort at reintegration. The difficulty of this first phase can not be underestimated. There are many paths that lead to living on the street and re-entry must often be tailored to a person's individual needs rather than the programatic needs of the shelter or agency.

The second tear of this approach involves mobilizing services to facilitate an individual's or family's transition toward more permanent housing. These services could include, physical and mental health services, social support, and employment assistance, in addition to continued housing assistance. It is in this phase that the person who is homeless will have to deal with the complexities of the array of programs available in Wisconsin. Many person who are homeless have in the past experienced difficulties in with these programs and agencies. Thus there is a need for strong supportive individual advocacy in this critical period.

The third tear or phase involves placement in or assistance in securing, long term housing, employment if appropriate, and the organization of continuing support if required. The success of this phase depends on the availability of permanent housing and on the prevention of the re-emergence of the conditions that led to the person becoming homeless. For example, securing of employment where income is too low to pay the rent will almost certainly lead to eviction and another episode of homelessness without some continuing

economic support.

This three phased or three teired approach has evolved in several countries and U.S. states. It recognizes that the problems of the person whc is homeless are immediate and can not be defered until long term solutions are worked out. In other words, there is little to recomend a policy that allows people to freeze while permanent housing is constructed. Likewise a policy that only provides emergency shelter (and traps people in the lowest teir) is equally unacceptable.

Current Wisconsin Programs

How does the present array of programs and services in Wisconsin compare with this model? Are there changes that would improve the effectiveness of existing programs with regard with the homeless population? As previously noted most of the services that would form the building blocks of a three tiered approach to the problem of homelessness already exist in Wisconsin.

Of particular interest here is the person who is mentally ill and homeless. When examined from the point of view of the person who is both mentally ill and homeless access to array of services is constricted by the rules, practices, and eligibility requirements of most services.

In the first tier most shelters and voucher programs in the state do not serve with severe current mental disturbance (such as being psychotic). Agencies that directly shelter the homeless population serve a higher percentage of people who are mentally ill than other types of agencies. But almost all agencies deny access to their services if the person appears to be in crisis or actively disruptive. This is a very difficult situation for the provider, particularly when a referral to a mental health facility will not likely lead to a committal. The provider is then faced with the options of refusing

service or attempting to deal with an individual who may be very disruptive to other clients, staff, or referral providers (eg to motel operators in the case of voucher programs)

Recommendation State and local mental health agencies should work with each program providing shelter, directly or indirectly, to the homeless population to articulate a 'secure referral' process. Such a process would provide a shelter-of-last-resort for people that the program would not serve because of apparent mental illness but who are not clear candidates for committal procedures. The existence of the shelter-of-last-resort should be made known 'on the street' and to referral agencies (including such groups as churches and the police). Funding for such shelter provision should be a priority in the States budget initiatives. This might include a 75/25 ratio of matching for those agencies who would serve as a shelter-of-last-resort.

To the person who is homeless access may present a considerable barrier. The rules, practices, and eligibility requirements of most shelters and programs are well known 'on the street'. A person may not seek shelter knowing that they will be denied or because the burden of the shelter bureaucracy. Many individuals voice the fear that if they use a shelter or other program when they are in crisis they will be institutionalized. Again the person will 'choose' to remain on the street for fear of the consequences of seeking shelter. It must also be acknowledged that people who are homeless are often afraid of the violence, degradation and vulnerability to victimization that they feel, particularly in shelters. These (too often valid) fears lead to 'choice' of the street as a safer place than the shelter.

Vigorous street-based outreach, 'zero level shelters', and 'warm
A Coordinated Approach

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rooms' all attempt to provide highly accessible, minimal structure services. Although part of the first tier such services are by their nature, very difficult to formalize within current social service models. Not only are the modes of operation unorthodox, often involving extensive 'bending' of the rules, long periods spent in establishing contact with a potential client, and intensive case management where contact is established, but there is often little change in terms of life style or apparent quality of life. Moreover the people and agencies most skilled at this type of work may not necessarily be public agencies or the trained personnel usually sought for social work positions. For example, the average "burn-out" period for street workers in New York City is six months for social workers but up to a year for volunteers-- a critical difference when attempting to re-engage a person who is homeless. It is also true that church based and volunteer-run programs have much higher 'street acceptance' than public shelter programs. Thus use of the normal accountability, quality, and outcome measures is of questionable use in evaluating such programs.

Recommendation Development of public policy toward the homeless population should recognize the diversity of the population in terms of backgrounds, problems, needs and capacities for change. Policies should avoid broad classifications of people since one major reason that people are homeless is that they did not fit into existing programmatic classifications.

Recommendation Any initiative in the area of homelessness should recognize that the homeless population is difficult to reach and shelter at least in part because of their past experience with public agencies. Effective actions will likely come from locally based groups or agencies, many of whom will be private in nature, and who have built up strong linkages with people in need in their communities. The structure of these groups which make them particularly successful with the homeless

(flexible, informal, accepting of lack of change) may not make program administration particularly easy. It should be the goal of funding sources to adapt to meet the needs of such groups. While public accountability should be preserved, unnecessary and unduly complex regulations should be waived so that the funds can support such innovative programs.

Recommendation Specialized facilities that serve particular segments of the homeless population should be supported when such facilities might ease the barriers to the homeless person. For example, separate facilities for women in Milwaukee and Madison seem justified, because in both cities there is concern for those women who are afraid to use existing facilities.

In the second tier the initial task is to mobilize resources to assure shelter and income. Once a person is assured a minimal level of housing and income security it becomes possible to address other areas of need which may be preventing the person securing permanent housing. Many of the services that might be required at this stage are well established. For example, in most larger communities in Wisconsin, mental health and social services, employment training and placement, and housing services are all available. The problem for many people who are attempting to stabilize their living situation is one of access. The need for identification (such as birth certificates, permanent address), and in some cases financial resources (for security deposits, commuting costs etc) may effectively exclude a person who is homeless from existing services. In other cases the lack of coordination between existing agencies may undermine the effective functioning of the system. For example, securing housing beyond a reasonable commuting distance to a community mental health care center may not be effective since it may lead to the person withdrawing from treatment.

The missing link for many people who experience recurring homelessness is sustained case management. A person who is homeless could have several case managers, a shelter worker, a general relief worker, and a housing counselor, but if a problem occurs it may well be the responsibility of the person in crisis to coordinate all these worker's plans. This coordination will be in addition to securing food and shelter as well as any other needs such as health care or employment training. Public and private programs often lack the resources necessary to offer this kind of sustained assistance in negotiating the complexities of "the system".

Recommendation The state and localities should examine existing programs and assure that people who are homeless are served (even if that means modifying current program requirements). The state could provide strong leadership in this area by mandating and enforcing the requirement that all state funded programs serve the homeless population, and that all programs recognize shelters as valid addresses for administrative purposes. Such a mandated approach has worked well in other states (Mass. for example) and would have an immediate impact.

Recommendation The State should anticipate passage of a federal homeless Persons Act by examining federal "pass through" programs to identify those programs whose local implementation also may inadvertently exclude people who are or have recently been homeless.

Recommendation All agencies involved in discharging clients should review their practices to assure that discharge does not lead to homelessness. There is a special need to plan for young people leaving foster homes and other placements. These young people may lack the job skills and training necessary to secure adequate incomes.

Recommendation Sustained coordinated case management should be encouraged between agencies. Shelter and transitional residence workers are best placed to have sustained daily contact with the person who is homeless, so other agencies should be encouraged to place workers directly in shelters or transitional residences. For instance, there should be a mental health care

worker in each major shelter or transitional residence, who would serve the clients in that shelter or transitional residence. This service may be as an advocate with other agencies, a coordinator of daily activities or simply as a source of continuity. To a person with a history of fragmented, inconsistent, and sometimes conflicting even rejecting treatment such a contact may effect more stabilization than any other single activity.

A major gap in Wisconsin services available to people who are homeless is assured transitional housing. Shelters now serve both as emergency shelter and transitional housing. Individuals must compete for shelter each night so that the person is in a constant state of anxiety as to their nightly shelter. Voucher programs usually only pay for 1 to 3 nights accomodation so again the person has no sense of stability. Many states and localities have found that separate facilities (such as duplexes, small houses, existing YMCAs and YWCAs, and independent apartments) can serve as assured temporary housing for the period when a person is getting their situation in order. Such facilities can be the locus of stability and continuing support. For example, a person may need assistance negotiating the public housing authority requirements or in securing employment. By staffing such residences with personnel skilled as housing and employment counselors the person who is attempting to leave homelessness is provided with both the security of assured housing and people who are immediately available to assist in the next steps to more permanent housing. As with emergency shelter provided in the first tear the goal of the second tear is to move a person on more secure living situations.

Recommendation Localities should set aside some housing units to be used for transitional housing. A program using duplexes

already exists in Milwaukee. Expansion of the number of emergency (tier 1) beds available should be critically examined in the light of the need for more secure (tier 2) housing. Agencies may be reluctant to reallocate resources to such facilities (for example, should the housing counsellor come from the emergency shelter budget or the housing authority budget?). The state may be able to play a leadership role without significant outlay of funds by establishing a demonstration program that would fund counsellor positions in transitional housing facilities and serve as an inducement to set up this type of program.

Recommendation Special attention should be paid to the transitional housing of people with particular needs. For instance, there is a need transitional housing for people with severe mental illness. Many individuals who are not acceptable to shelter providers are nonetheless in need of housing. Transitional housing for these people may take the form of small housing units, rather like group homes, but with the intention of providing a transition between the street and more permanent housing. People may spend up to a year or more in such 'minimal structure/maximum focus' residences.

The third phase in the process of leaving homelessness can be thought of as involving increasing stability in many areas of a person's life. Adequate stable income sources must be established (either via employment, entitlement programs or a mixture of sources); access to adequate physical and mental health care (as appropriate) is also necessary, social support must also be organized if required. In effect the third tier of this approach aims at assisting the individual to secure permanent housing and the means to hold on to that housing. There is a critical difference between placement of a person who is homeless in housing, and organizing a network of resources that will allow the person to stay in that housing on a long term basis.

The availability in Wisconsin of a range of housing, employment and support services provides a firm foundation for assembling a 'resource package' tailored to meet the needs of individuals. A young AFDC mother may need training (with quality day care) and employment and supportive social services. An older person may require physical health care and adult day care. A person with mental illness may need connection with a community mental health program and a semi-structured living environment (such as a YMCA or YWCA) but no other special services.

Because of the range of needs of people who are homeless and the existence of programs that meet most of these needs (albeit on a piecemeal basis) separating the homeless population as a special target group would only serve to further stigmatize individuals and would not necessarily lead to increased resources. Rather than looking to the people as the problem, programs can be examined to determine why they are failing people who are homeless. For example, training programs that do not include child care, employment situations that do not allow absences for necessary physical or mental therapy, or housing that does not provide access to desired activities (such as employment, social and recreational opportunities) may not serve the needs of very low income people.

Within the array of resources needed by people who are homeless, housing is critical. Providers of services list housing as the major unmet need as do advocates for people who are homeless. The 1985

State Housing Plan has as a goal to

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Provide decent quality housing at affordable cost, located and designed to meet the needs of households whose incomes are so low they cannot participate effectively in the housing market without assistance, and for households with other special housing needs.

Considering the needs of people who are homeless a variety of housing options are desirable. The continuum of housing services could range from non-structured facilities such as private apartments, duplexes or houses, to more structured living situations such as SROs, YWCAs and YMCAs, group homes, and boarding homes. In recognizing the diversity of the homeless population it is not surprising that their housing needs will be as diverse as those of the general community. The major difference is the inability of people who are homeless to compete in the housing market because of their low incomes.

The need for the preservation and even construction of SRO types of accommodation is a good example of the difficulty in securing housing at the lower end of the housing market. Although the need is widely recognized the private market is not producing this type of accommodation due to the lack of profitability of SROs since they must meet minimal safety and maintenance regulations. Public providers of housing loans may also be reluctant to finance such developments because most of their residents will have no income at all.

Yet if the State of Wisconsin is to fulfill the promise of the State Housing Plan innovative solutions must be found. Low Income Housing Task Forces are currently studying the situation in Milwaukee and Madison. With the findings of these studies available detailed plans can be formed for those cities. Faced with the same types of problems in developing long term housing other state and localities have developed a series of initiatives. Massachusetts has earmarked a significant amount of new unit construction for large families, The City of New York has developed partnership arrangements with private charities, usually churches, to run SROs, and many communities have developed public/private real estate partnerships for the construction and/or operation of very low or no-income housing.

Recommendation The State of Wisconsin should make a commitment to the development of housing for all its residents. Development of this housing will require a partnership between existing governmental bodies, corporations, foundations, housing authorities, advocacy groups and private charities. The State should take a leadership role in bringing together these actors in addressing the needs of very low income people.

Recommendation The State should study the appropriate structure of public/private programs to assist private voluntary organizations in providing housing for people with special needs. These organizations often lack the capacity and capital resources to initiate housing programs. Facilitating voluntary organizations can be a way of promoting housing for vulnerable people without significant involvement of public monies.

Recommendation WHEDA is in a unique position to provide leadership, expertise, and financing for the development of low income housing. Its policies and procedures should be reviewed to determine the extent to which WHEDA can participate in the development of SRO and other innovative projects. Production of this type of housing should have priority in the WHEDA agenda.

Recommendation Innovative housing demonstration projects should be supported by the State. The long lead time, cost and developmental difficulty involved in testing new and innovative housing solutions calls for housing initiatives to be tested and

the results distributed in the most efficient manner. The State is in a position to assist in the development of such programs by providing linkage to other programs, by providing some financial assistance, by evaluation studies, and by wide dissemination of the results.

Recommendation Existing housing programs may inadvertently exclude people who are or have recently been homeless. A review of their rules is necessary. The State can play a leadership roll in such a review by mandating it for its own programs but also by the development of guidelines for the use of smaller governmental units who may lack the resources to develop their own review procedures.

Recommendation Existing programs which assist low income individuals to remain in the present housing should be encouraged. Early intervention is perhaps the least expensive and least disruptive course of action. Two programs now exist and the state and localities should be encouraged to spread them further.

While the critical need is for housing other factors should not be ignored. Unless housing is provided on a free basis, stable sources of income are necessary to prevent homelessness. As previously noted the third tier involves the securing of housing and the means of holding on to that housing. That may mean income support for members of the working poor particularly single heads of households. It may mean increasing general assistance housing payments so that they cover the cost of housing. Finding ways to increase income levels of the very poor may also include training and re-training (which may require some changes to employment training programs).

Construction of An Integrated Approach in Wisconsin

The building blocks for a concerted effort on behalf of the homeless population of Wisconsin are already available or could be made available relatively quickly. The major problem in the development of such an effort will be the effective leadership required to bring together the broad range of actors who shape the reality of people who are homeless. Because so many of the programs that affect the person who is homeless are either mandated, funded or regulated by the State, any plan must have heavy State involvement. The State is also the only body capable of mobilizing the human and financial resources that will be required.

The State is not the only actor. Indeed much of the expertise in dealing with the problem of homelessness is to be found in the voluntary organizations and public agencies who provide shelter and services for people who are homeless. Foundations, churches and private individuals who support the work of the agencies are also major actors. So are advocates for people who are homeless, associations supporting people with mental illness or alcoholism, and low income advocacy groups. A long run solution will also require the involvement of the housing industry and employers. These actors will be critical in the development of adequate affordable housing and the primary means of holding on to that housing, employment.

State involvement will not solve the homeless problem in Wisconsin but

without State involvement the problem will not be solved. The State is in the position to bring together the diverse actors, experts, advocates and the victims of homelessness. With strong leadership at the highest levels coordination between governmental departments and cooperation between the public, private, and charitable sectors can be effective in focusing resources on the problem of homelessness. In Wisconsin where the level of social services is relatively high the need for massive amounts of financial resources is unlikely. Nonetheless some additional funds will be required. These funds can come from redirection of programs that are not yet serving the homeless population, or from new funds raised by the public or private sectors.

Conclusion

Growing recognition that people who are mentally ill may be particularly vulnerable to becoming homeless has led to a range of initiatives at local, state, and national levels. Just as there is no simple answer to how the problem developed there is no simple solution. Thus there is quite a range of approaches to identifying both the dimensions of homelessness and ways of dealing with the problem. Initial studies aimed at getting accurate counts of the number of people on the street, and providing sufficient shelter space. While this remains an ongoing concern, many agencies and research studies are now turning to considerations of longer term solutions. In many communities the immediate crisis has been met, at least in part, so that there is now the possibility of planning for more than emergency shelter.

Long run solutions to the problem of homelessness will be neither simple nor inexpensive. Service delivery to vulnerable individuals as well as those already on the street is likely to involve rethinking or delivery models. There is a need to re-examine models, particularly with respect to the multiple problems that persons who are homeless often have to deal with on a daily basis. While some agencies are already deeply involved in service delivery to people who are vulnerable or actually homeless, a wider involvement will probably be necessary for long term solutions to be successful. Agencies and

groups not normally associated with persons great distress will likely be crucial because their actions can have profound effects. A decision to convert an apartment house to condominiums, to demolish an abandoned building, to change a building code, or to change security deposit policies can have direct implications for people on the margins of the housing market. While service agencies may be very aware of the impact of even slight changes in eligibility rules there is a much broader group of actors that have a the problem will thus necessarily rest on the development of consensus among service agencies, and a range of public and private individuals and groups.